LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

BULLETIN 2016-01

TO: **ALL HEALTH INSURANCE ISSUERS AND HEALTH MAINTENANCE ORGANIZATIONS**

FROM: **JAMES J. DONELON, COMMISSIONER OF INSURANCE**

RE: **EXTENSION OF TRANSITIONAL RELIEF**

DATE: **March 15, 2016**

The purpose of Bulletin No. 2016-01 is to inform all health insurance issuers and health maintenance organizations (issuers) that pursuant to La. R.S. 22:1095(F) and consistent with federal guidance issued on February 29, 2016, and attached hereto, transitional relief in both the individual market and small group market is authorized to the extent consistent with the attached guidance and with prior guidance where applicable, at the option of each issuer.

Baton Rouge, Louisiana, this 15th day of March 2016.

JAMES J. DONELON
COMMISSIONER OF INSURANCE

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: February 29, 2016

From: Kevin Counihan, Director, Center for Consumer Information and Insurance Oversight

Title: Insurance Standards Bulletin Series -- INFORMATION – Extension of Transitional Policy through Calendar Year 2017

Subject: Extended Transition to Affordable Care Act-Compliant Policies

I. Purpose

On November 14, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a letter to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. CMS announced in its November 14, 2013 letter that, if permitted by applicable State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS further stated that, under the transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2014 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met. On March 5, 2014, CMS extended the transitional policy for two years – to policy years beginning on or before October 1, 2016 – in the small group and individual markets.

As provided in the November 14, 2013 and March 5, 2014 guidance, policies subject to the transitional relief are not considered to be out of compliance with the following provisions of the Public Health Service Act (PHS Act):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;[1]

[1] We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plan coverage.

- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage); and
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials);

Additionally, policies subject to the transitional relief are not considered to be out of compliance with section 1312(c) of the Affordable Care Act (relating to the single risk pool requirement). As a reminder, issuers can choose to adopt one or all of these provisions in their renewed policies.

CMS indicated in its March 5, 2014 guidance that it would consider the impact of the two-year extension of the transitional policy in assessing whether an additional one-year extension is appropriate.

II. Guidance

We are committed to smoothly bringing all non-grandfathered coverage in the individual and small group markets into compliance with all applicable PHS Act sections, including those relating to single risk pools, no later than 2018. Therefore, we will extend our transitional policy to policy years beginning on or before October 1, 2017, provided that all policies end by December 31, 2017. Specifically, States may permit issuers that have renewed policies under the transitional policy continually since 2014 to renew such coverage for a policy year starting on or before October 1, 2017; however, any policies renewed under this transitional policy must not extend past December 31, 2017. We will work with issuers and States to implement this policy, including options such as allowing policy years that are shorter than 12 months or early renewals with a January 1, 2017 start date. This approach will facilitate smooth transitions from transitional coverage to Affordable Care Act-compliant coverage, which requires a calendar year policy year in the individual market.

States can elect to extend the transitional policy for shorter periods than outlined above (but may not extend it beyond these periods).[2] Furthermore, States may choose to adopt the extended transitional policy in the following manner:

- For both the individual and the small group markets;
- For the individual market only; or
- For the small group market only.

Under the extended transitional policy, health insurance coverage in the individual or small group market that meets the criteria of the extended transitional policy and associated group health plans of small businesses, as applicable, will not be considered to be out of compliance with the market reforms as specified above. Health insurance issuers that renew coverage under this extended transitional policy, must, for each policy year, provide the relevant attached notice

[2] Following enactment of the Protecting Affordable Coverage for Employees Act (Pub. L. 114-60), the transitional policy in the March 5, 2014 guidance for certain eligible large employers no longer applies. However, States that elect to expand the definition of small employer to 1-100 employees may, under State law authority, choose to provide transition relief to these employers, as appropriate.

to affected individuals and small businesses as specified in our November 14, 2013 and March 5, 2014 guidance.[3]

All transitional policies that have rate increases subject to review under PHS Act section 2794 should use the rules and processes for submission to States and CMS that were in place prior to April 1, 2013, and updated April 1, 2015,[4] to assure compliance with PHS Act section 2794 requirements.

III. Where to get more information

If you have any questions regarding this guidance, please e-mail CCIIO at marketreform@cms.hhs.gov.

[3] Because these are required standard notices that cannot be modified, the Paperwork Reduction Act does not apply to these notices.

[4] See CMS Rate Review Justification Instructions for Transitional Policies and Student Health Plans (April 1, 2015), available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RRJ-Instructions-Manual-20150401-Final.pdf.

Attachment 1

This notice must be used when a cancellation notice has already been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,

We previously notified you that your current policy is being cancelled because it does not meet the minimum standards required by the Affordable Care Act. We are now writing to inform you that, consistent with federal guidance initially announced in November 2013, and extended in March 2014, you may keep this coverage for the upcoming policy year.

How Do I Keep My Current Policy?

To keep your current policy, please contact us.

As you think about your options, there are some things to keep in mind. If you choose to renew your current policy, it may NOT provide all of the protections of the Affordable Care Act. These include one or more of the following new protections of the Public Health Service Act (PHS Act) that were added by the health care law and took effect for coverage beginning in 2014. If you choose to renew your current policy, your coverage:

• May not meet standards for fair health insurance premiums, so you might be charged more based on factors such as gender or a pre-existing medical condition, and it might not comply with rules limiting the ability to charge older people more than younger people (PHS Act section 2701).

• May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).

• May not meet standards for guaranteed renewability (PHS Act section 2703).

• If the coverage is an individual market policy, may not meet standards related to pre-existing medical conditions for adults, so it might exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704).

• If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).

• May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).

• May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost-sharing (PHS Act section 2707).

• May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

How Do I Choose A Different Policy?

You have options for getting quality health insurance. [You may shop in the Health Insurance Marketplace, where all policies meet certain standards to help guarantee health care security, and no one who is qualified to purchase coverage through the Marketplace can be turned away or charged more because of a pre-existing medical condition. The Marketplace allows you to choose a private policy that fits your budget and health care needs. You may qualify for tax credits or other federal financial assistance to help you afford health insurance coverage purchased through the Marketplace.][5]

[You can also get new health insurance outside the Marketplace.] All new policies guarantee certain protections, such as your ability to buy a policy even if you have a pre-existing medical condition. [However, federal financial assistance is not available outside the Marketplace.] You should review your options as soon as possible, because you may have to buy your coverage within a limited time period.

How Can I Learn More?

To learn more about the Health Insurance Marketplace and protections under the health care law, visit HealthCare.gov or call 1-800-318-2596 **or TTY: 1-855-889-4325.**
If you have questions, please contact us.

[5] The bracket language does not apply to the U.S. territories that do not have a Marketplace.

Attachment 2
This notice must be used when a cancellation notice has not yet been sent and the issuer is providing an option to the policyholder to continue the existing coverage:

Dear Policyholder,
We are writing to inform you that, consistent with federal guidance initially announced in November 2013 and extended in March 2014, you may keep your existing coverage for the upcoming policy year.

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• May not meet standards for guaranteed availability, so it might exclude consumers based on factors such as a pre-existing medical condition (PHS Act section 2702).

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• If the coverage is an individual market policy, may not meet standards related to discrimination based on health status (PHS Act section 2705).

• May not meet standards for non-discrimination with respect to health care providers (PHS Act section 2706).

• May not cover essential health benefits or limit annual out-of-pocket spending, so it might not cover benefits such as prescription drugs or maternity care, or might have unlimited cost sharing (PHS Act section 2707).

• May not meet standards for participation in clinical trials, so you might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

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